Ombudsman Ombwdsmon

PUBLIC SERVICES OMBUDSMAN FOR WALES
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU

The investigation of a complaint against Swansea Bay University Health Board

A report by the
Public Services Ombudsman for Wales
Case: 201806963

Contents	Page

Introduction

This report is issued under s16 of the Public Services Ombudsman (Wales) Act 2005.

In accordance with the provisions of the Act, the report has been anonymised so that, as far as possible, any details which might cause individuals to be identified have been amended or omitted. The report therefore refers to the complainant as Mrs R and to Mrs R's mother as Mrs T.

Summary

Mrs R raised concerns about the care her late mother, Mrs T received from Abertawe Bro Morgannwg University Health Board which, since the time of the events has changed its name to Swansea Bay University Health Board ("the Health Board"). Mrs R complained that on 26 and 27 June **2017** the Health Board failed to take prompt and appropriate action to assess and treat Mrs T's symptoms of a stroke. She also complained that during Mrs T's consequent admission to hospital, the Health Board failed to ensure adequate monitoring and care of Mrs T's fluid balance and nutritional needs, take prompt and appropriate action to investigate the cause of Mrs T's distended abdomen and bowel symptoms, and manage Mrs T's anxiety.

The Ombudsman found that there was no appropriate assessment of Mrs T's risk of a stroke, even when her family raised concerns that she appeared to have a left-sided weakness, facial droop and slurred speech. Furthermore, when doctors were asked to review Mrs T in light of her family's concerns on the 26 and 27 June, two separate clinicians failed to document their attendance, their assessment or their findings and a third noted no reference to whether any symptoms of potential stroke were considered. By the time Mrs T's stroke was diagnosed on the afternoon of 27 June it was too late to administer thrombolytic medication, although it was not possible to say for certain whether this would have limited the damage caused by the stoke or reduced Mrs T's resulting disabilities.

The Ombudsman also found that there were further shortcomings in record keeping throughout the period of care. This made it impossible to determine what food and drink Mrs T consumed and suggested that her fluid balance was unregulated. The Ombudsman concluded that Mrs T was probably malnourished given her significant weight loss during her admission. However, this was not appreciated or addressed because of omissions and errors in the records and Mrs T was not referred to a dietician until 3 weeks after she should have been. It was unclear whether these shortcomings resulted in a significant impact on Mrs T's clinical condition, but they led to worry and frustration for Mrs T's family, who saw that she was not eating and was rapidly losing weight, and to uncertainty as to whether Mrs T's nutritional deficit might have compounded her other symptoms.

The Ombudsman considered that the Health Board took appropriate action to investigate Mrs T's bowel symptoms during her admission. Whilst no specialist advice was sought from a Gastroenterologist, which might have been helpful, it was unlikely that her treatment or management would have been any different even if such a referral had been made. There was no indication that specialist input or investigation was required until 22 August, when Mrs T dramatically deteriorated. However, by the time Mrs T was taken for a stomach X-ray on 23 August, Mrs T was critically unwell. The Ombudsman found there was a failure to reconsider whether to proceed with the X-ray given Mrs T's deterioration and sadly, as Mrs T was being returned to the ward after the X-ray, she died.

Finally, the Ombudsman found that Mrs T experienced severe and prolonged anxiety and was probably suffering from delirium during her admission. The treatment she received for this was, overall, appropriate and the decision not to prescribe ongoing sedatives was acceptable clinical practice, because Mrs T was at high risk of breathing difficulties. However, he felt that specialist input should have been sought. This might have provided some reassurance to Mrs R, who felt that her concerns and her requests for more to be done were being dismissed and ignored. Furthermore, a specialist should have been able to suggest whether there was any other type of medication or intervention available to alleviate Mrs T's anxiety without the associated risks of a sedative.

The Health Board agreed to the Ombudsman's **recommendations** that, within **one month** of the date of his report, it should:

a) ensure that all clinicians involved in Mrs T's care have the opportunity to consider the findings in this report and demonstrate that those individuals whose actions have been criticised have reflected on how they can improve their practice in future

b) remind all doctors in the Emergency Department and the Medical Assessment Unit of the First Hospital of the importance of documenting their attendance and assessment of patients, as well as any examination findings and outcomes

c) demonstrate that it has appropriate processes in both the First and Second hospitals to enable ward staff to access specialist input from other specialities

d) apologise to Mrs R for the failings identified in this report.

The Health Board agreed to the Ombudsman's **recommendations** that, within **three months** of the date of his report, it should:

e) provide evidence that it has adopted an appropriate, recognised stroke risk assessment scoring system and taken action to ensure that all doctors in the Emergency Department, Medical Assessment Unit and the stroke ward of the First Hospital have been informed and trained on how to apply it

f) review the training records of all doctors in the Emergency Department, Medical Assessment Unit and the stroke ward of the First Hospital, and provide refresher training to those whose training is not up to date on the recognition and treatment of TIAs and stroke, with particular reference to the most recently published NICE guidance

g) carry out a random sampling audit of patients' nursing records on the stroke wards of both hospitals, with a particular emphasis on completion of nutrition and fluid balance charts, and take action to address any identified trends or shortcomings.

The Complaint

1. Mrs R raised concerns about the care her mother, Mrs T received from Abertawe Bro Morgannwg University Health Board which, since the time of the events has changed its name to Swansea Bay University Health Board ("the Health Board"). Mrs R complained that on 26 and 27 June **2017**, after Mrs T attended the Emergency Department ("ED") following a fall at home, the Health Board failed to take prompt and appropriate action to assess and treat Mrs T's symptoms of left-sided weakness, facial droop and slurred speech.

2. Mrs R also complained that during Mrs T's consequent admission to hospital and until her death on 23 August, the Health Board failed to:

a) ensure adequate monitoring and care of Mrs T's fluid balance and nutritional needs

b) take prompt and appropriate action to investigate and treat the cause of Mrs T's distended abdomen and bowel symptoms

c) treat and manage Mrs T's anxiety.

Investigation

3. I obtained comments and copies of relevant documents from the Health Board and considered those in conjunction with the evidence provided by Mrs R. I also sought professional advice from Elizabeth Mullaney, a Consultant in Acute Internal Medicine ("the Acute Medicine Adviser"), Charlotte Morrison, a Dietician ("the Dietetics Adviser") and Imroz Salam, a Gastroenterologist ("the Gastroenterology Adviser").

4. The Advisers were asked to consider whether, without the benefit of hindsight, the care or treatment had been appropriate in the situation complained about. I determine whether the standard of care was appropriate by making reference to relevant national standards or regulatory, professional or statutory guidance which applied at the time of the events complained about. I have not included every detail investigated in this report but I am satisfied that nothing of significance has been overlooked.

5. Both Mrs R and the Health Board were given the opportunity to see and comment on a draft of this report before the final version was issued.

Relevant National Institute for Care and Excellence guidance

6. The Clinical Guideline 68, Stroke (2008) provided guidance on the diagnosis and initial management of acute stroke and transient ischaemic attack (TIA).[1] The signs and symptoms of stroke and TIA are the same, although in TIA the symptoms usually resolve within minutes or hours. It noted that patients who no longer have neurological symptoms at the time of assessment (within 24 hours) should be assessed using a valid stroke assessment scoring system; those at high risk should be assessed by a specialist and prescribed aspirin.

The background events

7. Mrs T was 87 years old with a history of recurrent falls, high blood pressure, diabetes and heart failure, when she fell at home early in the morning on 26 June **2017**. She was taken to hospital ("the First Hospital") by ambulance and was examined by a junior doctor who carried out a full physical assessment. No evidence of a stroke or any neurological deficit, which might indicate weak or abnormal function of the brain, was found at that time.

8. Mrs T was moved into the Medical Assessment Unit, where a Consultant ("the Consultant") reviewed her; a chest X-ray had revealed that fluid was building up in Mrs T's lungs owing to worsening heart failure. The Consultant noted that Mrs T remained fully awake and alert and was moving all four of her limbs. At 16:30 a nurse documented that a doctor had been asked to review Mrs T again, owing to the family's concerns of a new left-sided weakness. There was no entry by the Doctor who attended but the Nurse noted that he had not found any evidence of weakness and that no action was taken.

[1] In May 2019 the National Institute for Health and Care Excellence Guideline replaced CG68 with the new guideline NG128 on stroke and transient ischaemic attack in over 16s: diagnosis and initial management.

9. At 10:30 the next day the Consultant noted that Mrs T seemed well and was sitting out of bed in her chair; he did not document any consideration of a potential neurological deficit. The Health Board later said that a Medical Registrar reviewed Mrs T again at 11:40 because nursing staff had reported she was showing a possible left sided weakness. This was confirmed by the Medical Registrar although no other definite abnormality was detected. However, the Medical Registrar did not document his/her review or their findings in Mrs T's medical records.

10. The Consultant returned at 14:50 during a routine ward round; it was noted that Mrs R said symptoms of left-sided weakness and slurred speech had been present since the previous afternoon and had worsened since that morning. On examination Mrs T was alert but inattentive with persistent weakness to her left side, and her speech was slurred. The Consultant ordered an urgent scan, which showed evidence of damage to the right side of Mrs T's brain. The Consultant documented a discussion with Mrs T's family at 15:40, in which he confirmed that Mrs T had suffered a stroke but because of the uncertainty around the time of onset, it was not considered appropriate to prescribe thrombolytics (medication to break up and prevent blood clots). Mrs T was transferred to a stroke ward.

11. Over the next 2 weeks or so Mrs T began to lose weight and became periodically anxious and agitated. On 10 July Mrs T was transferred to a stroke ward at another hospital ("the Second Hospital"). Her weight continued to drop and she became increasingly agitated; it was noted that she was not sleeping at night and was continually calling out and ringing for nurses although did not appear to need anything when they attended. Mrs R and her family began bringing in food and having meals on the ward to try to encourage Mrs T to eat. However, despite Mrs T's weight loss, her risk of malnutrition was not reviewed between 14 July and 9 August.

12. Between 21 and 30 July Mrs T was prescribed sedatives at night but by 31 July it was noted that Mrs T was still not sleeping well; the sedatives were stopped as they were not seeming to help. Both the nurses and the doctors noted that ward staff would try to keep the area quiet and to look in on Mrs T periodically during the night, to try to help her sleep better.

On 7 August a doctor noted that he wanted to avoid prescribing sleeping tablets or sedative medications because they can reduce breathing rates and mask problems with patients' lungs.

13. On 9 August it was noted that Mrs T had lost 7.3kg but an error in the calculation of her risk of malnutrition resulted in Mrs T being assessed as "moderate risk". No referral to a dietician was made at that time. Two days later nursing staff reported to doctors that the family were concerned Mrs T's stomach was swollen. When she was examined by a doctor it was noted that Mrs T had passed loose stools although her stomach was soft and non-tender and normal bowel sounds were heard.

14. On 14 August Mrs T was again prescribed a sedative because she remained anxious and agitated. Mrs R said that on 16 August she requested her mother be referred to a psychiatrist to help manage her mother's anxiety. No such referral was made. Records showed that on the same day Mrs T had lost a significant amount of weight and the next day she was referred to a dietician, who prescribed fortified drinks to improve Mrs T's nutritional intake.

15. On 22 August it was noted that Mrs R thought her mother was drowsier and unable to pass stools. When Mrs T was examined that evening there was no evidence that she was constipated but the Doctor noted hyperactive bowel sounds, which can indicate an increase in activity within the digestive system. He planned to consider a stomach X-ray to check for a possible bowel obstruction with a senior colleague at ward round the next day.

16. At morning ward round on 23 August Mrs T was noted to be drowsy and her stomach remained soft and non-tender with hyperactive bowel sounds; the stomach X-ray was ordered. However, half an hour later Mrs T's stomach was distended, she vomited and became unresponsive; it was noted that her prognosis was poor and it appeared that she would be unlikely to tolerate ventilation. By 14:45 Mrs T was unable to breathe without oxygen therapy and it was noted that carbon dioxide was building up in her bloodstream. Shortly thereafter Mrs T was transferred to Radiology to undergo an X-ray of her stomach. Sadly, as she was being made comfortable on her return to the ward at 15:40 Mrs T died.

17. In January **2018** Mrs R and her family raised a formal complaint with the Health Board. On 20 February Mrs R attended a meeting with the Health Board to discuss her concerns, at which it was noted that no appropriate stroke test had been carried out.

18. On 11 January **2019** the Health Board issued its complaint response. It apologised for shortcomings in its communication with Mrs R, including the length of time it had taken to complete its complaint investigation and offered £250 in recognition of this. It conceded that there was uncertainty as to the time of the onset of Mrs T's symptoms but stated that this was because of the transient nature of her symptoms and not the result of any deficiency in care. It also acknowledged that the standard of record keeping was inadequate; although initially at low risk in terms of her nutrition, when Mrs T's eating reduced, her food intake and fluid balance were not monitored, charted or reviewed regularly. Consequently, her risk of malnutrition was not calculated accurately which resulted in the referral to the Dietician being delayed by 18 days. Furthermore, when the family began bringing in food the nursing staff did not discuss with them the importance of ensuring that anything Mrs T consumed should be documented. The Health Board apologised for these shortcomings and confirmed that it had reminded ward staff of the importance of ensuring documentation is completed accurately, including input from relatives where appropriate.

Mrs R's evidence

19. Mrs R said that as a qualified nurse, she was able to recognise symptoms of stroke. She believed that her mother suffered the stroke on 26 June but said that her concerns were overlooked and Mrs T was not adequately assessed until it was too late to give her appropriate treatment. Mrs R said that the Health Board should have listened to the family members who knew her mother best. She also said that she and her brother have suffered from emotional distress as a result of the events culminating in their mother's death and from having to go through a lengthy complaint process.

20. Furthermore, Mrs T steadily lost weight throughout her admission but Mrs R's requests for specialist nutritional input were also dismissed until it was too late. Mrs R also said that Mrs T became more anxious as time went on; she was experiencing hallucinations and wanted someone with her all the time. However, no specialist psychiatric input was sought to manage these symptoms either.

The Health Board's evidence

21. The Health Board maintained that it was not appropriate to prescribe thrombolytics owing to the uncertainty around the time of the onset of Mrs T's transient stroke symptoms and her relative frailty. It also explained that it is common for elderly patients to suffer with irregular bowels while hospitalised and that this was not seen as a major cause for concern for Mrs T because her stool samples were normal and her blood test results did not indicate that she was dehydrated or malnourished. Mrs T's bowel movements were charted appropriately, and her prescribed laxatives were adjusted accordingly.

22. The Health Board said that Mrs T would have been offered water, hot drinks and food in accordance with the usual routine practice on the ward. It denied that Mrs T had suffered delirium but said that her frequent anxiety was related to her increasing shortness of breath.

23. The Health Board acknowledged how difficult Mrs T's death, shortly after returning to the ward on 23 August, must have been for Mrs R and her family, and it offered its condolences. It appeared that Mrs T's bowel had been impaired which, by 23 August had caused a build-up of food in her intestines which resembled the symptoms of an obstruction when no blockage was actually present. It said that when this caused Mrs T to deteriorate that morning, it was not perceived that her death was imminent. Therefore, more medication was prescribed and an investigation was warranted to assess whether the cause of her deterioration was reversible.

Professional Advice

24. The Acute Medicine Adviser said that:

- The Junior Doctor conducted a full assessment after Mrs T arrived at the First Hospital and there was no evidence of a stroke at that time. However, the Consultant's assessment later that morning was far less comprehensive. Furthermore, it was impossible to judge the assessment conducted by the Doctor later that afternoon because there was no medical documentation to record what he considered or what he found.

- Given the concerns Mrs R raised about Mrs T's left-sided weakness, an appropriate stroke assessment should have been conducted. It was difficult to say how high Mrs T's risk would have been but given her age, symptoms and medical history, Mrs T's score, had it been calculated, would probably have indicated she was at high risk of a stroke.

- More than 3 hours elapsed between the Nurses noting that a possible left-sided weakness had been developing and worsening into the afternoon on 27 June and the Consultant's assessment. This suggested that Mrs T could have had an earlier CT scan and possibly also thrombolysis within the recommended time interval. However, it was impossible to know whether thrombolysis would have had any impact on Mrs T's condition or her outcome because it does not work well in every case.

- Appropriate action was taken to treat Mrs T after her stroke was diagnosed given that it was outside of the treatment window for thrombolysis to be prescribed. The chances of clinical benefit from thrombolytics significantly diminishes beyond 3 hours from the onset of symptoms.

- There was no evidence in the records that Mrs T experienced hallucinations, but she experienced a high level of agitation despite nurses noting that they were attending her every 20-30 minutes. This, along with her excessive drowsiness noted by 17 August, suggested that Mrs T was suffering with delirium.

- Sedatives can cause a patient with heart failure affecting the lungs (like Mrs T) to stop breathing so it was not inappropriate to withhold them. However, given Mrs T's prolonged and recurrent anxieties at night and her difficulties sleeping, specialist psychiatric advice should have been sought to determine whether anything else could have been done to address her anxiety, without the risk to her breathing.

- The documentation available was inadequate to establish the amount of food and drink Mrs T consumed. It was therefore impossible for the Nursing and Medical teams to know whether she was taking enough to meet her needs.

- There were several entries within the medical records that demonstrated appropriate plans were put in place, depending on Mrs T's bowel movements, to prescribe laxatives when she was constipated and withhold them when she had diarrhoea. However, given the length of time that Mrs T experienced bowel problems, advice should have been sought from a gastroenterologist.

- Given her clinical presentation, Mrs T was not well enough to leave the ward for an abdominal X-ray on 23 August.

25. The Dietetic Adviser said that:

- The poorly completed food and fluid balance charts made it very difficult to estimate Mrs T's nutritional intake. Nevertheless, it was reasonable to infer that it was probably inadequate given that Mrs T was at high risk of malnutrition and lost a clinically significant amount of bodyweight during her admission.

- Mrs T should have received nutritional support sooner, which would probably have been prescribed earlier if she had been referred to the Dietician promptly and might have reduced her weight loss. However, whilst medical conditions such as stroke and heart failure increase the metabolic demands of the patient and increase energy requirements, it was not possible to say for certain that improved nutritional intake would have ultimately changed Mrs T's clinical outcome.

- The Dietician's assessment on 17 August was limited because ward staff had failed to maintain accurate food and fluid charts for the previous 5 days. Nevertheless, she accurately assessed Mrs T's nutritional requirements and made appropriate recommendations for nutritional supplements.

26. The Gastroenterology Adviser said that:

- Bowel irregularities commonly occur in elderly hospital patients who are less mobile and do not usually require input from a gastroenterologist unless specific new symptoms develop. Mrs T's constipation and diarrhoea were symptomatically treated appropriately and examinations of her stomach, rectum and stool analyses were all normal. This did not suggest that specialist input was required, until her deterioration on 22 August.

- Furthermore, Mrs T's treatment would probably not have changed even if a specialist referral had been made because it was appropriate to manage Mrs T's symptoms conservatively. Consequently, there was no negative clinical impact from the decision not to seek an opinion from a gastroenterologist and it was unlikely that Mrs T's care, or her ultimate clinical outcome, would have been different.

- It was noted that Mrs T had deteriorated an hour after the X-ray was requested, and her prognosis at that time was already thought to have been poor. Therefore, it would probably have been more appropriate to have cancelled the X-ray and to have provided care and comfort on the ward, with discussions with the family about whether further intervention was appropriate.

Analysis and conclusions

27. When considering clinical care, I do not apply a "gold standard" test to the service provided by the NHS, nor do I consider care provided with the benefit of hindsight. My role has therefore been to assess whether the original clinician's approach was reasonable at that time and under the circumstances even if with hindsight, there might be things that could have been done differently or better. During my investigation I have weighed the evidence available on the balance of probabilities to draw conclusions which, whilst informed by the comments of the Advisers, are my own.

28. I am unable to conclusively determine when Mrs T suffered her stroke, notwithstanding that it appears to have occurred after she was admitted. I am satisfied that the assessment conducted by the Junior Doctor on 26 June was appropriate and that there was no evidence of a neurological deficit at that time. Additionally, whilst the Consultant's subsequent entry detailing his review was brief, I recognise that no concerns had been raised by that point that Mrs T might have experienced a possible stroke. However, the evidence does not support that the family's suspicions later in the afternoon were adequately considered, despite nursing staff communicating them to doctors. The failure of both the Doctor on 26 June and the Medical Registrar on 27 June to document their attendance makes it impossible for me to establish precisely what they considered or what examinations they might have carried out. In addition, the Consultant's assessment the next morning made no reference to whether any symptoms of potential stroke were considered at all.

29. I acknowledge that Mrs T's left-sided weakness might have been transient but this cannot be confirmed. It is unacceptable that the record keeping was inadequate to allow me to ascertain precisely what happened and to allow the Acute Medicine Adviser to evaluate the care provided. On balance, the concerns raised by Mrs R in relation to her mother's symptoms were consistent on both days and there is scant contemporaneous evidence that they were properly investigated. There is nothing to confirm that either TIA or stroke was considered or that Mrs T's risk was assessed using an appropriate stroke scoring system. Consequently, there is considerable uncertainty as to whether there were failures to assess Mrs T appropriately

and to identify any TIA or stroke symptoms which might have been present, irrespective of their possible transience, between the afternoon of 26 and the morning of 27 June.

30. Moreover, even if Mrs T's stroke symptoms were not present, or persistent until the morning of 27 June, the Acute Medicine Adviser has suggested that thrombolytics should have been considered earlier and I agree with her. Nursing staff recorded concerns on 27 July that Mrs T had a left-sided weakness which gradually worsened into the afternoon. However, there was no documented assessment until the Consultant's ward round more than 3 hours later and even then, the diagnosis was delayed pending the outcome of the CT scan. Given the recommended time interval between the onset of symptoms, diagnosis and administration of treatment, I am concerned that the apparent lack of urgency to establish the full clinical picture and to take action represents another missed opportunity to investigate and treat Mrs T's symptoms. That said, it is impossible to state for certain whether thrombolytics would have limited the damage caused by the stroke or reduced Mrs T's resulting disabilities.

31. Whilst I am unable to conclude with certainty for how long the opportunity to identify and treat Mrs T's symptoms existed, I am of the opinion that these failings represent significant injustice to Mrs R and her family. Firstly, there is no evidence that their concerns were given adequate consideration and secondly, it questions whether more could have been done if those symptoms were present and had been confirmed earlier. There will always be an element of doubt as to whether and/or to what extent those omissions might have compromised Mrs T's care and her recovery. In view of all of the above, I **uphold** this element of the complaint.

32. I am concerned to note that there were further shortcomings and omissions in record keeping which made it impossible, both for Mrs T's treating clinicians and for me, to determine what food and drink Mrs T consumed. Nonetheless, I accept the opinion of the Dietetic Adviser that it is reasonable to conclude that Mrs T was effectively malnourished in light of her increasing level of risk and significant weight loss throughout her admission. Additionally, it is concerning to note that despite Mrs T's heart failure, fluid retention and periodic diarrhoea, her fluid balance was neither regulated nor recorded.

33. I note that Mrs R and her family took it upon themselves to attempt to try to encourage Mrs T to eat and drink, and whilst I accept that this can be an effective technique when patients decline food and drink, this should not absolve hospital staff of their duties to ensure adequate monitoring and care. It is difficult to say whether nursing staff made sufficient efforts to encourage Mrs T to improve her poor fluid and dietary intake because there is insufficient record of when, or why, food and drink was declined (or taken). That said, it does not appear that the rate Mrs T was losing weight, or her apparent nutritional deficit, was fully and promptly appreciated because her risk scores were often unrecorded and on one occasion, miscalculated and the referral to the Dietician was delayed by nearly 3 weeks.

34. It is unclear whether these shortcomings resulted in a significant clinical impact for Mrs T. The Dietetic Adviser was unable to deduce whether an earlier prescription of nutritional supplements would have had a clinical impact on her condition, or her outcome, notwithstanding that Mrs T's clinical condition probably increased her body's requirements for nutrition. In any event, it was clearly worrying for Mrs R and her family to see Mrs T failing to eat and rapidly losing weight. Furthermore, there is an element of uncertainty as to whether this might have compounded Mrs T's other symptoms which I have been unable to resolve. Therefore, whilst I appreciate that the Health Board has already apologised for the omissions in Mrs T's food and fluid charts and the delayed referral, I **uphold** this element of the complaint.

35. I am not persuaded that the Health Board failed to take appropriate action to investigate and treat the cause of Mrs T's bowel symptoms. I recognise that Mrs T's various and fluctuating bowel problems caused worry and concern for Mrs R and her family, and were probably unpleasant for Mrs T. Nevertheless, the Advisers agreed that such problems occur commonly in elderly hospitalised patients and that, moreover, appropriate action was taken to address the symptoms according to Mrs T's clinical presentation. Whilst the Acute Medicine Adviser suggested that specialist input should have been sought sooner, the Gastroenterology Adviser was clear that the Health Board's management was appropriate and that her treatment would probably not have changed even if a referral had been made.

36. However, I consider that Mrs T's critical condition by the afternoon of 23 August should have prompted clinicians to reconsider whether it remained appropriate to transfer her to Radiology to X-ray her stomach. Both the Acute Medicine Adviser and the Gastroenterology Adviser agreed she was too unwell by that point. That said, I recognise that events can unfold at a brisk pace in a clinical environment and that at the time the X-ray request was made it was appropriate. Therefore, I **partially uphold** this element of the complaint to the limited extent of the failure to reconsider whether to pursue the stomach X-ray on 23 August.

37. I accept the Acute Medicine Adviser's opinion that the Health Board's reluctance to prescribe sedating medication to Mrs T was acceptable clinical practice. Mrs T was suffering with heart failure and difficulties breathing throughout her admission, and it was necessary for clinicians to balance the risk that sedation might have precipitated a worsening of those conditions and/or caused her to stop breathing. It seems to me that the treatment provided was therefore appropriate and I note that ward staff implemented a conservative management programme, which included maintaining a calm and quiet environment at night and offering Mrs T frequent reassurance.

38. That said, Mrs T experienced prolonged and severe anxiety and I agree with the Acute Medicine Adviser that her symptoms suggested she was suffering from delirium. Notwithstanding that the treatment provided appears to have been appropriate, I also agree that specialist input should have been sought. This might have also provided some reassurance to Mrs R, who felt that her concerns and her requests for a psychiatric opinion were being dismissed and ignored. Furthermore, a specialist should have been able to suggest whether there was any other type of medication or therapeutic intervention available to alleviate Mrs T's anxiety without the associated risks of a sedative. The uncertainty as to whether Mrs T's anxiety might have been better controlled is an injustice because it was distressing both for Mrs T and for her family. I **partially uphold** this element of the complaint to the extent that, whilst the care provided was not inappropriate, psychiatric input should have been obtained.

39. I am issuing this report as a public report because there are wider lessons for all health boards across Wales to learn from this case. Firstly, there were failures by 2 separate clinicians to record the key consultations with Mrs T. I am concerned this might indicate a systemic failure within the Health Board and that the lack of recording has left the family with the uncertainty of not knowing whether the clinical outcome might have been improved for Mrs T, which is a serious injustice to them. Secondly, I am struck by Mrs R's comment that the Health Board should have listened to family members, who knew Mrs T better than hospital staff. Opportunities were lost by the Health Board to act upon the family's concerns in a timely manner.

40. Furthermore, my office has reported on failures of this kind by this Health Board in the past.[2] I urge the Health Board and indeed, all health boards in Wales to reflect upon the learning from this case to ensure that families' concerns are given proper consideration.

The Health Board's response to the draft report

41. In its response to the draft report, the Health Board offered its sincere apologies to Mrs R and her family for the failings identified, and the Chief Executive offered to meet Mrs R personally to convey this and to gain personal insight from the family's perspective. It also offered the opportunity for Mrs R to work with the Health Board to produce a "patient story" to facilitate wide learning and to promote understanding of the effects of clinicians and nursing staff not listening to the concerns raised by the family of a patient. Finally, the Health Board offered Mrs R an ex-gratia payment of £2,000 in recognition of the failings identified and the consequences for Mrs T and her family.

42. I very much welcome the Chief Executive's response to my draft report and the willingness on the part of the Health Board to involve Mrs R's family to ensure lessons are learned from the failings identified in this case.

[2] Previous decision case reference 201001670

Recommendations

43. I **recommend** that, within **one month** of the date of this report, the Health Board should:

a) ensure that all clinicians involved in Mrs T's care have the opportunity to consider the findings in this report and demonstrate that those individuals whose actions have been criticised have reflected on how they can improve their practice in future

b) remind all doctors in the Emergency Department and the Medical Assessment Unit of the First Hospital of the importance of documenting their attendance and assessment of patients, as well as any examination findings and outcomes

c) demonstrate that it has appropriate processes in both the First and Second hospitals to enable ward staff to access specialist input from other specialities

d) apologise to Mrs R for the failings identified in this report.

44. I **recommend** that, within **three months** of the date of this report, the Health Board should:

e) provide evidence that it has adopted an appropriate, recognised stroke risk assessment scoring system and taken action to ensure that all doctors in the Emergency Department, Medical Assessment Unit and the stroke ward of the First Hospital have been informed and trained on how to apply it

f) review the training records of all doctors in the Emergency Department, Medical Assessment Unit and the stroke ward of the First Hospital, and provide refresher training to those whose training is not up to date on the recognition and treatment of TIAs and stroke, with particular reference to the most recently published NICE guidance

g) carry out a random sampling audit of patients' nursing records on the stroke wards of both hospitals, with a particular emphasis on completion of nutrition and fluid balance charts, and take action to address any identified trends or shortcomings.

45. I am pleased to note that in commenting on the draft of this report **Swansea Bay University Health Board** has agreed to implement these recommendations.

Nick Bennett 5 February 2020
Ombudsman

Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

Tel: 01656 641150
Fax: 01656 641199
Email: ask@ombudsman-wales.org.uk
Follow us on Twitter: @OmbudsmanWales